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6. **Establishment of Rate Year 1996 Standardized Capital Payment Amounts:** The 1992 and 1994 base year standardized average capital cost per case were trended to rate year 1996 to account for (a) inflation related to capital investment and (b) anticipated DRG coding changes from 1992 to 1996.

   (a) Each peer group's 1992 average capital cost was inflated to rate year 1996 using the Prospective Payment Assessment Commission's (ProPAC) capital update factors.

   (b) Each hospital's own 1994 average capital cost was inflated to rate year 1996 using the Prospective Payment Assessment Commission's (ProPAC) capital update factors.

   (c) 1996 updated capital payment amount were reduced by 8% to account for expected DRG coding improvements that are projected to occur during the 1992 through 1996 rate years and as specified in Section D5(b).

7. **Standardized Capital Payment Amounts for Rate Year 1996:** The Bureau has established three standardized capital payment amounts: one standardized amount for major teaching hospitals, a second for nonmajor teaching hospitals in large urban areas, and a third for all remaining hospitals.

   (a) For rate year 1996, the updated 1992 standardized amount for the major teaching peer group is $290.41

   (b) For rate year 1996, the updated 1992 standardized amount for the large urban peer group is $261.55

   (c) For rate year 1996, the updated 1992 standardized amount for the all-other peer group is $202.33

   (d) Capital payment will be a weighted average of each hospital's peer group and own-hospital amounts until 1999. Use of the hospital's own costs will be phased out over four years to its respective peer group amount.

   (e) The separate peer group amounts for nonmajor teaching hospitals will also be phased out over four years.

      (1) for rate year 1996, the updated 1992 all non-major teaching hospital peer group amount is $206.

   (f) The combined capital phase out schedule between own capital costs and peer group amounts is displayed in Attachment B.

   (g) Each hospital's capital payment is a strictly prospective amount with no retrospective adjustments.

   (h) There are no appeals and no adjustments for extraordinary capital expenditures, unless capital is spent by individual hospitals to meet federal or state regulatory requirements.

8. **Updating Beyond Rate Year 1996:** The peer group capital costs and each hospitals' own capital costs will be updated beyond rate year 1996 by the following methodology:

   (a) The methodology for updating beyond rate year 1996 will follow the methodology specified in Section G6.

   (b) Peer group capital costs will be updated beyond rate year 1996 by ProPAC's capital cost factor using the ProPAC methodology. Beginning in 1998, capital cost shall be updated using HCFA's capital input price index (CIPI) as reported in the Federal Register. Beginning in 2000, peer group capital costs will be updated using the CIPI adjusted for the forecast correction in the Federal Register.

   (c) The Hospitals' own capital costs will be updated by using more current hospital-specific data.

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(d) The Bureau will update the peer group capital costs no less frequently than every five years.

H. **DIRECT MEDICAL EDUCATION:** The Bureau has adopted a policy to pay teaching hospitals for their direct medical education (DME) costs which largely follows the current Medicare DME policy. Each teaching hospital will be paid a DME amount that is equal to the Bureau's share of total inpatient days multiplied by the total hospital reimbursable DME costs.

1. **DME Payments for Rate Year 1996:** DME payments will be made on a lump-sum basis, rather than a per case prospective basis, at the end of each calendar year quarter.

2. **Basis of the DME Payments:** Direct medical education costs under the prospective payment system are defined using Medicare's definition and include the following:

   (a) salaries and fringe benefits of interns and residents;

   (b) salaries attributable to the supervisory time of teaching physicians and other teacher salaries;

   (c) costs of nine related general overhead service cost centers appropriately allocated to the medical education cost centers;

   (d) appropriate costs from the employee benefits, administration and general, and cafeteria overhead service cost centers are allocated to resident salaries.

   (e) applicable costs from all nine general service cost centers allocated to the other teaching program cost categories: capital related costs--building & fixtures; capital related costs--movable equipment; employee benefits; administration and general; maintenance & repair; operation of plant; housekeeping; cafeteria; and maintenance of personnel.

3. **Definition of FTE Residents:** The number of FTE residents is determined according to where they are assigned, the length of time spent in a residency program, and their foreign medical graduate (FMG) status, and using the following rules:

   (a) Residents assigned to a PPS-excluded unit or facility are not counted toward a PPS hospital's FTE total.

   (b) If a resident spends time in more than one hospital, the resident's time is prorated to each PPS hospital to total no more than one FTE.

   (c) FTE resident status is based on the total time necessary to fill a residency slot. If a resident spends only 70 percent of the time necessary to fill a residency slot, that resident counts for at most 0.7 FTE.

      (i) For an "initial" residency period, defined as the number of years required to meet board eligibility in a specialty plus one year (up to a limit of five years), the weighting factor is 1.0.

      (ii) The weight falls to 0.5 for residents beyond the initial residency period.

      (iii) FMGs who fulfill the necessary requirements before their residency begins receive equal weight to

U.S. medical graduates while those FMGs not meeting the appropriate criteria receive a weight of zero.

4. **Establishing Per-Resident Cost Amount:** The following methodology was used to establish per-resident cost amounts for each teaching hospital:

(a) Medicare-allowable per-resident amounts were derived from Supplemental Worksheet E-3 in each hospital's 1994 Medicare cost report.

(b) The per-resident amount is the weighted average of the OB/Gyn-primary care and non-primary care per-resident amounts used by Medicare.

(c) The per-resident amounts established in H4(b) were updated through rate year 1996 by the most recent (1994) Urban Consumer Price Index (CPI-U). An annual growth rate of 2.56% was used compounded for two years.

5. **Establishing Share of Total Inpatient Days:** Total hospital DME costs for the 1996 rate year will be paid by the Bureau according to its own share of total inpatient days. Share of total inpatients days was determined using the following methodology:

(a) Number of hospital days in total and by type of payer was obtained from the W. Virginia Health Care Cost Review Authority for 1994 .

(b) For each teaching hospital, the total number of hospitalization days for Bureau for Medical Services patients was divided by total number of hospitalization days across all payers to yield the percentage of total days.

6. **Establishing Maximum DME Costs:** The Bureau has established a maximum number of FTE non-primary care interns and residents eligible for DME payments and a maximum per resident allowable amount.

(a) The limits on the maximum number of residency positions for specialists, as specified in H3, was applied when counting the number of full-time residents.

(b) The per resident amount in the base year, 1994, was capped at the rate of the fifth most costly hospital out of ten teaching hospitals in the state.

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(I) Each of the five capped hospitals receive a two-year inflation update on the maximum allowable 1994 cost per resident, or $37,899 in 1996.

7. **Calculation of the Rate Year 1996 DME Payments:** Each teaching hospital will be paid a DME amount that is equal to the Bureau's share of total inpatient days multiplied by the total hospital reimbursable DME costs.

(a) Total DME costs for teaching hospitals for rate year 1996 are calculated as the product of the hospital's total FTE residents and the established per-resident amount.

(b) For each teaching hospital, the Bureau's share of DME costs is calculated by multiplying total DME costs by it's share of total hospital days as established in H5.

8. **Updating Beyond Rate Year 1996:** The Bureau will recalculate the Direct medical education adjustment factor on an annual basis using the most currently available data from the Medicare cost reports and the methodology specified in Sections H1 through H7.

I. **PAYMENT FOR TRANSFER CASES:** The Bureau makes a distinction in its prospective payment system between cases that are discharged after completing a full course of treatment and cases that are transferred between two acute care facilities.

1. **Definition of Transfer Cases:** Transfer cases are defined as those cases that are transferred between two acute care facilities for continuation of care.

2. **Basis of Payment for Transfer Cases:** Similar to Medicare's PPS, the Bureau pays transfer cases on a graduated per diem basis up to the full DRG payment amount.

(a) Transfer cases receive three times the DRG-specific per diem amount, capped at the full DRG payment amount for nontransfer cases.

(1) The Bureau determined that the unadjusted average cost per care on the first day prior to transfer is three times higher than the average cost of care on all subsequent days.

(b) Transfer cases are eligible for high cost outlier payments and indirect teaching adjustments in addition to their graduated per diem payments.

(c) All sending hospitals receive a graduated per diem amount based upon the DRG to which the case is assigned for the sending hospitals phase of the treatment.

(d) The final discharging hospital receives a full DRG payment amount based upon the DRG to which the case is assigned for the final discharging hospital's phase of the treatment.

(e) Each phase of the hospitalization is assigned a DRG based upon the principal diagnosis and surgical procedures performed during the respective phase.

(f) Cases assigned to the two DRGs specific to transfer cases, DRG 385, Neonates that died or were Transferred, and DRG 456, Burn Cases that are Transferred, receive the full DRG payment.

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3. **Updating of Payment for Transfer Cases**: The Bureau will evaluate the need to modify the level of payment for transfer cases on an annual basis using the methodology as described in Sections I1 and I2.

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Inpatient Hospitals Located Outside the State of West Virginia

A. OUT-OF-STATE FACILITIES EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM: The prospective payment system applies to most acute care hospitals located outside the state of West Virginia. Cases treated in excluded facilities are paid under their current payment methodologies. The qualifying provisions for exempt facilities and units that are of relevance are as follows:

1. **Psychiatric Hospitals:** Psychiatric hospitals must meet the Medicare regulatory definition of a psychiatric hospital and be primarily engaged in providing psychiatric treatment of mentally ill patients.

2. **Rehabilitation Hospitals:** Rehabilitation hospitals and distinct-part units may qualify as excluded facilities if they meet the Medicare regulatory definitions and are primarily engaged in furnishing intensive rehabilitation services. Payment for inpatient rehabilitation hospitals is a cost-based retrospective system determined by applying the standards, cost reporting periods, cost reimbursement principles, and method of cost apportionment used under Title XVIII of the Social Security Act, prior to the Social Security Amendment of 1983 (Section 601, Public Law 98-21). This is, payment is to be determined by the current Medicare Principles methodology of cost-based reimbursement.

3. **Rural Primary Care Hospitals (RPCH):** Payment for cases treated in RPCH hospitals is based on Medicare's per diem payment methodology.

B. **CASES EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM:** All criteria applying to excluded cases for inpatient hospitals located within the state of West Virginia shall apply to inpatient hospitals located outside the state of West Virginia.

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C. **METHODS USED TO ESTABLISH DRG PAYMENT WEIGHTS:** Out-of-state inpatient hospitals included in the prospective payment system shall be subject to the same methodology for the establishment of DRG Payment Weights as facilities located within the state of West Virginia, the most current Medicare GROUPER.

D. **METHODS USED TO ESTABLISH PROSPECTIVE OPERATING PAYMENT RATE:** One operating payment will be used for all out-of-state hospitals: the current Medicaid instate Statewide operating payment amount.
Out-of-state Sole Community Hospitals will be given no special payment consideration. There will be no blending of the PPS payment amount with their costs.

E. **HOSPITAL ADJUSTMENTS TO STANDARDIZED OPERATING RATE PAYMENTS:**

1. **Wage Difference Adjustment:** All out-of-state hospitals will be assigned to one of the West Virginia market areas based upon their respective county's average hourly wage rate as calculated from the 1993 HCFA Wage Index File.

2. **Indirect Medical Education Adjustment:** An indirect medical education adjustment will be made to the out-of-state hospital's standardized operating payment amount. HCFA's IME adjustment factors will be used with an adjustment made to reflect the specialty and occupational policies in the Medicaid program.

3. **Level III NICUs:** The Level III neonatal DRGPAY amounts (DRG 585-590) will be used to make inlier payments for neonatal DRG payment amounts.

F. **METHODS USED FOR PAYMENT FOR HIGH COST CASES:** The same methods will be applied to out-of-state hospitals as those located within West Virginia.

G. **METHODS USED TO ESTABLISH PROSPECTIVE CAPITAL PAYMENT RATES:** Two West Virginia capital peer group amounts will be used for out-of-state hospitals: major teaching and nonmajor teaching. Unlike instate hospitals, all out-of-state hospitals' capital payment amounts will be solely based upon the two West Virginia peer group amounts, i.e., there will be no blending of the peer group amount with their own capital costs. Capital peer group amounts are updated annually.

H. **DIRECT MEDICAL EDUCATION:** There are no direct medical education payments to out-of-state Hospitals.

I. **PAYMENT FOR TRANSFER CASES:** The West Virginia instate transfer payment policy will be the basis of payment for all out-of-state transfer cases.